



**PHYSICIAN
EDITION**

Medicare & You 2002

This handbook has important information about:

- **Your Medicare benefits.**
- **Choosing a health plan that's right for you.**
- **New ways to get information.**

How do you find what you need? See page 97.



CENTERS FOR MEDICARE & MEDICAID SERVICES



Welcome to *Medicare & You!*

Dear Physician:

What's in a name? When Health & Human Services Secretary Tommy G. Thompson first announced that the name of the Health Care Financing Administration (HCFA) would change to the Centers for Medicare & Medicaid Services (CMS), a lot of people warned that it would take more than a name change to improve the agency's relationship with physicians.

I agree, and we are improving our services to you. Our new name signals our commitment to a culture of responsiveness, with increased outreach to physicians and other providers of services to Medicare beneficiaries. We have tripled the number of physicians occupying senior policy-making positions within the agency. Each of them brings to their tasks a personal awareness of the issues you face in treating patients. We also appointed the Deputy Administrator, Ruben J. King-Shaw Jr., to serve as a primary point of contact for physicians. He will be responsible for strengthening communications and acting as a liaison to you.

With considerable input from practicing physicians from around the country, an intra-agency team called the Physicians' Regulatory Issues Team continually reviews agency policies and procedures affecting physicians with a view toward streamlining, simplifying and clarifying them. We are increasing physician education and outreach and this special supplement is just one example. We are committed to working more closely and collegially with you to facilitate your relationship with Medicare, including addressing billing questions or errors.

Our goal is to make the Medicare program truly supportive of you as you provide care to people with Medicare. We hope you find your physician edition of the Medicare & You Handbook to be useful. If you have any questions or comments, please contact me at the address above or at doctor1@cms.hhs.gov.

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

What you will find in this physician insert

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The Medicare Learning Network at www.hcfa.gov/medlearn assists you with the proper submission of Medicare claims through a variety of educational materials and resources including:

- Information about the basics of coding and claims payment
- Quick Reference Guides for 'hot topics'
- Computer - based educational modules and products useful to you or your staff
- Resident training information, including a manual of Medicare basics useful to physicians at all stages of practice
- Educational product ordering, free of charge.

There are times when you need help determining the proper way to code and bill for specific services, or with problem-solving. Here are some resources.

1. Check your Medicare Carrier's website (www.hcfa.gov/medicare/incardir.htm)

Announcements about educational activities, answers to frequently asked questions, an on-line version of your Carrier Bulletin, information clearing up areas of concern/confusion, and more.

2. Contact your Medicare Carrier toll-free (www.hcfa.gov/medlearn/tollnums.htm)

We established these inquiry lines last fall and will be upgrading them with extra training and desktop resources in 2002. These service representatives are now required to identify themselves to you, and work hard to give clear answers to your billing questions. If they cannot provide an answer, there are more options for you, listed below.

3. Contact your Medicare Carrier's Medical Director (see your Carrier's website or toll-free line for information) Medicare carriers now have physician medical directors to assure policies are appropriate and problems are resolved.
4. Contact your Regional Office for the Centers for Medicare & Medicaid Services. (see Page 92 in this handbook for a list with telephone numbers)

In ten regional offices located across the country, we work with physicians, their professional associations, beneficiaries and others to assure that the program runs smoothly. These offices work closely with the Carriers. Many of these offices have physicians serving as Chief Medical Officers.

5. Contact Your Professional Association and ask that they work with us.

We value the input we receive from your associations, because they can aggregate your individual concerns and communicate these to our Carriers and/or us at CMS. This can lead to the identification of systemic problems or policy flaws, allowing us to correct them in a timely way.

6. Contact us directly at the Centers for Medicare & Medicaid Services.

We have established a special e-mail address to learn more about your needs, and where you may provide your reactions to this special insert. Contact us at doctor1@cms.hhs.gov.

The CMS Physicians' Regulatory Issues Team and staff at The Medicare Learning Network have collected this list of recent changes and improvements to the Medicare program.

Medicare Summary Notice (MSN) language improvement.

We have removed the phrase, “not medically necessary” from the MSNs that your patients see to reduce patient confusion. These notices now contain easier to understand language such as, "Medicare probably will not pay for..."

Advance Beneficiary Notice (ABN) improvement.

A new, improved ABN is now available. As of July 1, 2001, this new form may be used, and is considered to be a “model” notice. Once CMS publishes final instructions regarding its use, you will be required to use it. For information, replicable copies of the approved forms see www.hcfa.gov/medicare/bni.

Payment for Pre-operative evaluation.

By law Medicare does not pay for services that are “routine” (unless Congress specifically permits a payment, such as for mammograms, etc). Upon hearing that some Carriers were denying payment for pre-operative evaluation services (office visits and diagnostic tests performed by a physician other than the operating surgeon, for the purpose of assessing perioperative risk) on the basis that they were “routine” exams, we developed new instructions for all Carriers to follow. Program Transmittal #1707 instructs Carriers that Medicare does not consider services included as part of a pre-op evaluation to fall under the statutory exclusion for "routine examinations" and that Carriers should not deny these services as “routine” services. However, Carriers will continue to review these claims to determine if they are medically necessary, and may deny payment for them on that basis. CMS will track this issue over the next year to determine the effects of this new policy. Please let us know how the new policy is working.

Home Health Care - payments for physician Plan of Care certification and oversight.

Medicare pays separately for the following types of home health care-related physician services:

- Plan of Care initial certification - use HCPCS code G0180 when the patient has not received Medicare covered home health agency services for at least 60 days
- Plan of Care re-certification - use HCPCS code G0179 for re-certification after a patient has received services for at least 60 days (or one certification period).
- Care Plan Oversight - use HCPCS code G0181 for supervision of complex interdisciplinary home health care to a patient lasting 30 minutes or more in a calendar month that is in addition to any time spent in certification or re-certification.
- A Program Memorandum with more detail, once finalized, will be available at http://www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm.

Flu vaccine 2001.

Last fall, influenza vaccine shortages and high distributor prices caused problems for physician offices and their patients. We encourage immunization for Medicare beneficiaries and we worked closely with the Centers for Disease Control and others for an improved vaccination season this year. Early reports suggest some delays in shipment may again occur, so we recommend that you watch for information from the CDC and refer to the Quick Reference Guide: www.hcfa.gov/medlearn/refimmu.htm.

Clinical Trials - expanded coverage

Medicare pays routine costs for Medicare covered services to patients enrolled in approved clinical trials. For coverage policy see <http://www.hcfa.gov/coverage/8d.htm>. For a beneficiary brochure on clinical trials, see **page 21**. For additional information, see www.hcfa.gov/medlearn/refctmed.htm.

Preventive health- more Medicare services

- Colonoscopy - As of July 1, 2001, screening colonoscopy is covered every 10 years for all Medicare beneficiaries over age 50. It is still covered every two years for high-risk persons.
- Pap and pelvic exam with clinical breast exam - As of July 1, 2001, these tests are covered every 24 months instead of every 36 months. These tests are still covered annually for high-risk women.
- Glaucoma screening - As of January 1, 2002, Medicare pays for a screening glaucoma exam for beneficiaries at high risk of glaucoma or with diabetes or a family history of glaucoma. Instructions regarding this new benefit, once finalized, will be communicated as Program Transmittal #1717 at http://www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm.

Certificates of Medical Necessity

These forms are used to certify the need for certain Durable Medical Equipment. We have implemented revisions to our policy to help simplify the process. Refer to your DME Regional Carrier's website, www.hcfa.gov/medicare/incirdir.htm for details:

- Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists may write and sign CMNs, as long as they meet certain requirements.
- Facsimile is acceptable. Suppliers may dispense DME based on a CMN signed & faxed by the physician, nurse practitioner, certified nurse specialist or physician assistant.
- Corrections need not be signed in full. For changes made to Section B of the CMN, the physician, nurse practitioner, certified nurse specialist or physician assistant must line through the correction, and initial and date the change.

Physician self-referral law

Unless an exception applies, a physician may not refer a Medicare patient for a “designated health service” to a health care entity with which the physician (or immediate family member of the physician) has a “financial relationship.” For more information, including Frequently Asked Questions, see www.hcfa.gov/medlearn/refphys.htm.

News for physicians caring for patients in Medicare+Choice Plans

The following policies are included in a manual for Medicare+Choice that is under development and once finalized will be at www.hcfa.gov.

- Re-credentialing. M+C plans are now required to re-credential you every three years, instead of every two, making M+C standards consistent with those of the healthcare community and national accrediting organizations.
- Hospital privileges. Physicians in a M+C network are no longer required to have hospital admitting privileges, so long as the plan has an adequate panel of physicians with such privileges. Lack of privileges does not exclude a physician's participation in a M+C plan.
- Provisional hospital privileges. Physicians in a M+C network with provisional hospital privileges may care for patients while awaiting full hospital privileges.
- Attestation. Instead of submitting source documents regarding malpractice coverage and hospital admitting privileges, physicians may attest to this information.

ee Information For Your Patients

FREE PUBLICATIONS

Pages **9 -10** of this Handbook list free publications for your Medicare patients. For more than 25 copies fax a request to CMS at 410-786-1905. To preview or download these publications, go to www.medicare.gov, Publication section. In addition to English and Spanish, a number are translated into Chinese; many are available in Braille, large print, and audiocassette.

WEBSITE - www.medicare.gov

This patient-friendly website has a number of interactive databases that can assist your patients (and their caregivers) in making decisions. Currently available databases include:

Interactive Databases:	Features:	Search by:
Prescription Drug Assistance Programs	Programs offering discounts or free medication to patients in need. May require a physician to apply on behalf of the patient.	ZIP code, State, manufacturer, and condition or disease
Nursing Home Compare	Inspection reports on every Medicare and Medicaid certified nursing home in the country. Based on State Survey data.	State
Medicare Health Plan Compare	Detailed information on Medicare's health plan options.	State, ZIP code
Helpful Contacts	Local contact information to allow patients to find additional help (and/or counseling).	Organization, State
Local Medicare Events	Local events, health fairs, and educational opportunities.	State and month
Participating Physician Directory	U.S. physicians accepting Medicare payment rates.	Location, Specialty
Medigap Compare	Lists insurance companies selling Medigap (Medicare supplemental insurance) plans, with contact information.	State, ZIP code
Dialysis Compare	Facility characteristics (location, number of stations, hours of operation) and quality measures.	State
Medicare Personal Plan Finder	Comparison information about out-of-pocket costs; combines many of the above listed databases.	ZIP code
Supplier Directory	Contact information on Medicare Participating Suppliers.	State

BENEFICIARY TOLL FREE LINE: 1-800-MEDICARE

Beginning October 1, 2001, customer service representatives for your patients will be available 24 hours a day, 7 days a week at 1-800-MEDICARE (1-800-633-4227) in English and Spanish. TTY/TTD: 1-877-486-2048 for the hearing and speech impaired.

Dear Physician:

Medicare is a taxpayer-funded program and the Centers for Medicare & Medicaid Services (CMS) has a fiduciary duty to ensure that beneficiaries receive the maximum value for their invested tax dollars. Congress established Medicare's Integrity Program in 1996 to help reduce payment errors, and protect and strengthen the Medicare Trust Funds. In 1996, the Inspector General's Office estimated that Medicare made 14% of its payments improperly. Since then, we have made real progress in reducing the error rate to 7.97% in 1999 and to 6.78% in 2000.

Program Integrity's goal is to ensure that Medicare pays claims correctly. This means paying the correct amount, for a covered service, provided to an eligible beneficiary. Meeting our goal requires that we work collaboratively with our Medicare partners - physicians, beneficiaries, contractors and other staff and medical agencies to protect and strengthen the Medicare Trust Funds.

Please document your services, code them accurately, and submit your claims for the care that you provide. We recognize that honest mistakes can happen. Physicians making unintentional coding errors do not commit fraud, and CMS does not impose fines for coding errors. When we identify overpayments, we are required to recover them. Most are handled administratively. Only in rare circumstances does CMS refer providers to law enforcement agencies for further investigation.

Medicare pays more than 95% of submitted claims without reviewing medical records. If you are selected for medical review, this does not mean necessarily that Medicare suspects you of wrongdoing. Medical review selection is based on several factors. Typically, physicians selected for medical review are identified based on prior problems or atypical billing patterns. By reviewing information on the claim along with supporting information contained in the medical record, Contractors are able to make determinations about whether there is a problem.

If Medicare selects your claims for review, we expect persons conducting the review to treat you respectfully, courteously, and fairly. If you have questions about the medical review process, the reviewer should answer those questions in a timely manner.

We strive to pay claims accurately and to treat you fairly. If you have problems or concerns, please contact us through your professional association or one of the CMS Regional Offices (see page 92). For more information about Medicare Integrity Program, we recommend our recent publication, *Pay It Right* viewable online at: www.hcfa.gov/medicare/mip/mip.rtf.

Sincerely,

Timothy Hill, Director,
Program Integrity Group
Centers for Medicare & Medicaid Services

Q What is on the horizon in Medicare?

A program that truly supports doctors and other clinicians in caring for patients

Physicians' Regulatory Issues Team (PRIT)

This team has articulated a vision for the agency in which Medicare requirements are not simply less burdensome, but are truly supportive of physicians/clinicians in caring for patients. We gather input from practicing physicians across the country and listen to your concerns. The Administrator's Open Door initiative is building on this effort. Based upon the feedback we receive, the agency has undertaken a variety of projects, amplifying the voice of practicing physicians and concretely addressing your concerns. A number of changes highlighted in this insert are a result of this work, and the Physicians' Issues Project, below, tells of more efforts. Check in with us periodically at www.hcfa.gov/medlearn/prithome.htm.

Professional relations with your professional associations

The Agency has new leadership, a new name, and a renewed commitment to working closely with the associations that represent you. We conduct monthly conference calls for 150 physician associations, provide exhibits and educational material at more than 25 of your national meetings, support expansion of the work of Secretary Thompson's Practicing Physicians Advisory Council, and continue working with your representatives on other improvements.

Education, information and support.

www.hcfa.gov/medlearn and your Carrier's website are the places to "bookmark" and revisit often. Because we have received increased funding for education and outreach to physicians, the MedLearn website will quickly become a key source for speedy access to the latest in consistent, accurate, and authoritative Medicare information. Soon, we will add such features such as a Frequently Asked Questions site and improved web navigation that is more intuitive to the physician/clinician user. By using this resource, you will spend less time sorting through matters relating to claims and administration and more time on patient care.

Evaluation and Management documentation guidelines - simplification project.

We recognized the increased paperwork burden placed on physicians by the 1995/1997 guidelines and we are working to decrease this burden. We are working closely with physician associations and practicing physicians to accomplish this goal. For periodic updates on this project see www.hcfa.gov/medlearn/emdoc.htm.

Policy Experts "walk a mile in the shoes" of physicians and other clinicians.

Do you have an established community or County Medical Society - sponsored Internship Program allowing government officials and others to spend time with clinicians in their offices and hospitals? CMS staff recently participated in several such programs. We greatly benefited from the experiences and are interested in participating in your program, as time and funding permit. Contact us at doctor1@cms.hhs.gov.

Physicians' Issues Project

This special effort of the Physicians' Regulatory Issues Team targets specific Medicare requirements that physicians tell us adversely affects their day-to-day experiences with Medicare. This project is currently exploring a number of issues, working to address them in a way that makes it easier for you to care for your Medicare patients. For the status on these issues and periodic updates on the Project, see www.hcfa.gov/medlearn/prithome.htm. Here are a few of the issues under development:

- Glucose monitoring supplies - Physicians tell us the requirement that new orders for diabetic glucose monitoring supplies be re-written every six months is too frequent. We are looking at this requirement with agency leadership and aim to publish instructions soon.
- Certificates of Medical Necessity (CMNs) - CMNs and other forms of durable medical equipment (DME) comprise a large portion of the paperwork burden that physicians feel is excessive, therefore we are working to develop new ways to address this issue. This includes a possible pilot study to re-examine the use and effectiveness of the CMNs.
- Physician Supervision of Medical Residents - Under Medicare Part A, Graduate Medical Education payments are made to teaching programs for residents & teaching physicians. For extra fee-for-service payments under Medicare Part B, teaching physicians tell us requirements are confusing and documentation is excessive. We are reviewing this, and most immediately, we believe some improvements to the documentation requirements may be feasible.
- Clinical Labs - Working with physicians and others, we created standard national coverage policy for 23 lab tests. This instruction, once finalized, will be published in the Federal Register.

More physicians and more physician input at Medicare

CMS has tripled the number of physicians on staff at Medicare. Physicians work in strategic areas of the program, such as policy development, payment oversight, operations, education and outreach, regional offices, quality improvement, and as Carrier Medical Directors. Most have significant experience in patient care, and ALL are working to make the Medicare program responsive to the physicians caring for patients. In addition, we are creating new programs and mechanisms so that our policy staff hears more practicing physician input.

Contact us

The information in this supplement reflects improvements to the program over this past year, and our best sense of your interests and needs. If there are additional areas that we need to address, we want to know about them. Please contact us via the avenues listed on page i of this supplement, or at doctor1@cms.hhs.gov.

Questions On Medicare Coverage? Here are some resources.

Local: For your local carrier's policies (local medical review policies or LMRPs), check your carrier's website, call your carrier's toll-free line, or check our searchable national database of LMRPs at www.lmrp.net.

National: National coverage policies are contained in the Medicare Coverage Issues Manual, available on-line at http://www.hcfa.gov/pubforms/06_cim/ci00.htm. You can also track the progress of national coverage decisions at www.hcfa.gov/coverage/8a1.htm.

Medicare Information to Distribute from your Office

When people with Medicare and their caregivers are asked where they would like to get Medicare information, they say their physician's office. You can order booklets about Medicare's benefits, including skilled nursing facility care, hospice care, home health care, dialysis, preventive services, and woman's health. Give them to your Medicare patients and their families when they need specialized care. *The Guide to Choosing a Nursing Home* is also available and can help people through this difficult decision making process.

To order copies of these publications, look on pages 9-10. Prepare a list of the publications you want (with the publication number), the quantity you need, the name of a contact person, phone number, a complete shipping address (no PO boxes please), and any special delivery instructions (like inside deliver). Fax your request to Medicare at 410-786-1905.